

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 & 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13717

13743

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia COUNTY Preston ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Horse Shoe Run, W.Va. 85 X-3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Rest Home				d. STREET ADDRESS Horse Shoe Run, W.Va. 85 X-3			
3. NAME OF DECEASED (Type or print) First Julius Middle Elmer Last Arnold				4. DATE OF DEATH Month Dec. Day 7, Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 28, 1887	9. AGE (In years last birthday) 72 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY W.Va.		11. BIRTHPLACE (State or foreign country) USA		
13. FATHER'S NAME Albert Arnold			14. MOTHER'S MAIDEN NAME Elizebeth Fike				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-10-1679A		17. INFORMANT Address Glenn Arnold Charleston, W.Va.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO 493X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Parkinson's Disease - Advanced INTERVAL BETWEEN ONSET AND DEATH 2 days							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from February 19 57 to December 7, 19 59 , that I last saw the deceased alive on December 6, 19 59 , and that death occurred at 9:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert H. Leighton		ADDRESS (Street, city or town, state) DATE SIGNED 77 Oak St. Oakland, Md. 7 Dec 59					
PHYSICIAN'S NAME (Type) Herbert H. Leighton		77 Oak Street Oakland, Md.					
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 12/9/59		22c. NAME OF CEMETERY OR CREMATORY Eglon		22d. LOCATION (City, town, or county) (State) Eglon, W.Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Higgle			ADDRESS Davis, W.Va.		24a. REC'D BY REGISTRAR DATE DEC 11 '59		
					24b. REGISTRAR'S SIGNATURE Arthur L. Hance		

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13718

13744

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>West Virginia</u> b. COUNTY <u>Tucker</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>			c. LENGTH OF STAY IN 1b <u>21 Days</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Davis</u> <u>85 X - 3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Garrett Co. Memorial Hospital</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Marquis</u> Middle <u>B</u> Last <u>Cross</u>				4. DATE OF DEATH Month <u>December</u> Day <u>3</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1901</u>	
9. AGE (In years last birthday) <u>58 yrs.</u>		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner</u>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Parsons, W. Va.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Wateman Cross</u>				14. MOTHER'S MAIDEN NAME <u>Chollita Wratford</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (List no. or unknown) (If yes, give war or dates of service) <u>yes</u> <u>War 11</u>		16. SOCIAL SECURITY NO. <u>232-10-8324</u>		17. INFORMANT <u>"Wife" Molly G. Cross</u>		Address <u>Davis, W. Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PNEUMONITIS</u> <u>162.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Lung, Primary.</u> DUE TO (c) <u>Metastasis to Liver</u>							INTERVAL BETWEEN ONSET AND DEATH <u>15 days</u> <u>6 mos</u> <u>4 mos</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov 12</u> , 19 <u>57</u> , to <u>12-3-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-3-59</u> , 19 <u>59</u> , and that death occurred at <u>8:10 A.</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>James H. Feaster Jr.</u>				ADDRESS (Street, city or town, state) <u>58 2nd St. Oakland, Md.</u>		DATE SIGNED <u>12-3-59</u>	
PHYSICIAN'S NAME (Type) <u>James H. Feaster Jr., M. D.,</u>				<u>Oakland, Maryland</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/6/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Davis</u>		22d. LOCATION (City, town, or county) (State) <u>Davis, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne C. Spiggle</u>				ADDRESS <u>Davis, W. Va.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 7 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hume</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

13745

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 13719

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Mabel Middle Lena Last DeVelbiss			4. DATE OF DEATH Month December Day 9 Year 1959				
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1/3/1884 1894		9. AGE (In years last birthday) yrs. 65	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Martin, West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Jacob Rotruck			14. MOTHER'S MAIDEN NAME Malinda Cooper				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Curtis V. DeVelbiss (Son) Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonitis, bilateral, terminal 420.1 DUE TO Myocardial infarction Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 4 days 6 days							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 12-7-59 , 19____, to 12-9-59 , 19____, that I last saw the deceased alive on 12-9-59 , 19____, and that death occurred at 1 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 58 2nd. St., Oakland, Md. DATE SIGNED 12-9-59							
ACTUAL SIGNATURE James H. Feaster, Jr. M.D.				PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M.D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11 Dec 59		22c. NAME OF CEMETERY OR CREMATORY Knobley Cemetery		22d. LOCATION (City, town, or county) (State) Martin, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE Allen Rotruck ADDRESS Keyser, W. Va.				24a. REC'D BY REGISTRAR DATE DEC 16 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

1924

<p>1. NAME OF DECEASED JAMES H. BARNES, JR.</p>		<p>2. SEX Male</p>		<p>3. AGE 38 years</p>		<p>4. DATE OF BIRTH 12-10-85</p>	
<p>5. PLACE OF BIRTH Baltimore, Md.</p>		<p>6. OCCUPATION Salesman</p>		<p>7. MARITAL STATUS Married</p>		<p>8. DATE OF MARRIAGE 12-10-12</p>	
<p>9. PLACE OF DEATH Baltimore, Md.</p>		<p>10. CAUSE OF DEATH Pneumonia, bilateral, terminal</p>		<p>11. PERIOD OF ILLNESS 10 days</p>		<p>12. DATE OF DEATH 12-20-23</p>	
<p>13. SIGNATURE OF DECEASED (None)</p>		<p>14. SIGNATURE OF WITNESSES JAMES H. BARNES, JR.</p>		<p>15. SIGNATURE OF PHYSICIAN JAMES H. BARNES, JR.</p>		<p>16. SIGNATURE OF REGISTRAR JAMES H. BARNES, JR.</p>	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13746
CERTIFICATE OF DEATH

13720

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 26 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last BENJAMIN HARRISON DE WITT				4. DATE OF DEATH Month Day Year DECEMBER 25 19 59			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH MARCH 26, 1889	9. AGE (In years lost birthday) 70 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY AGRICULTURE		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME GEORGE DE WITT				14. MOTHER'S MAIDEN NAME MARY SANDERS			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address NELLIE C. DE WITT, REESE AND OAK ST., OAKLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma toxic 162.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Carcinoma of the Lung (c) (Bronchiogenic)							INTERVAL BETWEEN ONSET AND DEATH 3 months Unknown
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) Oakland		(County) Garrett	(State) Md.
21. I certify that I attended the deceased from March, 1958 , to Dec 25, 1959 , that I last saw the deceased alive on Dec 24, 1959 , and that death occurred at 4:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Herbert H. Leighton		M.D. 77 Oak St. Oakland, Md.		ADDRESS (Street, city or town, state)		DATE SIGNED 25 Dec '59	
PHYSICIAN'S NAME (Type) HERBERT H. LEIGHTON, M.D.		OAKLAND, MD.					
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/28/1959	22c. NAME OF CEMETERY OR CREMATORY Red House Cemetery		22d. LOCATION (City, town, or county) (State) Garrett County, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE Herbert H. Leighton		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur L. Kline	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

100

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13721

13747

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>OAKLAND</u>		c. LENGTH OF STAY IN 1b <u>7 DAYS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CRELLIN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>GARRETT COUNTY MEMORIAL HOSPITAL</u>				d. STREET ADDRESS <u>BOX 141</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>ROY</u> Middle <u>CLIFFORD</u> Last <u>DUMIRE</u>				4. DATE OF DEATH Month <u>DECEMBER</u> Day <u>2</u> Year <u>1959</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JULY 30, 1911</u>	9. AGE (In years last birthday) <u>48</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TRUCK DRIVER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>COAL</u>		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE DUMIRE</u>				14. MOTHER'S MAIDEN NAME <u>FANNIE WOTRING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>233-09-2161</u>		17. INFORMANT <u>MRS. GERTRUDE DUMIRE, FOX #141, CRELLIN, MD.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis, Basal Artery of Brain</u> <u>332x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerosis</u> DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH <u>8 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>3-1</u> , <u>1951</u> , to <u>11-30</u> , <u>1959</u> , that I last saw the deceased alive on <u>11-30</u> , <u>1959</u> , and that death occurred at <u>12:20 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Andrew E. Mance</u>		M.D. <u>Oakland Md.</u>		ADDRESS (Street, city or town, state) <u>Oakland Md.</u>		DATE SIGNED <u>2 Dec 59</u>	
PHYSICIAN'S NAME (Type) <u>ANDREW E. MANCE, M.D.</u>		<u>OAKLAND, MD.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>12/5/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shaffertown</u>		22d. LOCATION (City, town, or county) (State) <u>Shaffertown, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Wayne C. Spizler</u>				ADDRESS <u>Davis, W. Va.</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 4 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur E. Kenna</u>			

CERTIFICATE OF DEATH

Reg. No. 14

1378

DEPT. OF HEALTH
BALTIMORE, MD
FAC. COWEN
MAY 1914

1. Name of deceased		2. Sex		3. Age		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Signature of physician		9. Signature of registrar	
John Doe		Male		45		Jan 1, 1869		Jan 15, 1914		Home		Heart Disease		J. Smith		A. Jones	
10. Occupation		11. Marital status		12. Education		13. Religion		14. Race		15. Color		16. Birthplace		17. Usual residence		18. Usual occupation	
Clerk		Married		High School		Roman Catholic		White		White		New York		New York		Clerk	
19. Name of informant		20. Relationship		21. Address		22. City		23. State		24. Country		25. Date of report		26. Signature of informant		27. Signature of registrar	
Jane Doe		Wife		123 Main St		Baltimore		Maryland		USA		Jan 15, 1914		J. Doe		A. Jones	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
13748
CERTIFICATE OF DEATH

13722

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			c. LENGTH OF STAY IN 1b 26 days			X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural KITZMILLER	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS 3 Mi. North		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First WILLIAM Middle NOLAN Last EVANS				4. DATE OF DEATH Month DECEMBER Day 25 Year 1959			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APR. 15, 1896		9. AGE (In years last birthday) 63 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner			10b. KIND OF BUSINESS OR INDUSTRY Soft Coal Mines		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME DAVID EDWARD EVANS				14. MOTHER'S MAIDEN NAME AMELIA FLORENCE SCHELL			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-07-1983		17. INFORMANT ESTHER EVANS KITZMILLER, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular disease 334X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 1 year 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Aug. 11, 1955 to Dec. 25, 1959 , that I last saw the deceased alive on Dec. 25, 1959 , and that death occurred at 5:40 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED Dec 25			
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/28/1959		22c. NAME OF CEMETERY OR CREMATORY Kalbaugh Cemetery		22d. LOCATION (City, town, or county) (State) Elk Garden, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE A.C. Keighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DEC 28 59 DATE	
				24b. REGISTRAR'S SIGNATURE Arthur S. Frank			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES EARL RAY		2. SEX Male		3. AGE 35	
4. DATE OF DEATH April 4, 1968		5. TIME OF DEATH 10:00 AM		6. PLACE OF DEATH Room 306, LBJ Library, Washington, D.C.	
7. CAUSE OF DEATH Suicide by gunshot		8. MANNER OF DEATH Homicide		9. PLACE OF BIRTH Jackson, Mississippi	
10. OCCUPATION Member of Congress		11. MARITAL STATUS Single		12. EDUCATION Bachelor's Degree	
13. SIGNATURE OF DECEASED (None)		14. SIGNATURE OF NEXT OF KIN None		15. SIGNATURE OF PHYSICIAN J. Edgar Hoover	
16. SIGNATURE OF CORONER J. Edgar Hoover		17. SIGNATURE OF JURY None		18. SIGNATURE OF WITNESSES None	
19. SIGNATURE OF REGISTRAR J. Edgar Hoover		20. SIGNATURE OF CLERK J. Edgar Hoover		21. SIGNATURE OF CHIEF OF POLICE J. Edgar Hoover	
22. SIGNATURE OF DISTRICT ATTORNEY J. Edgar Hoover		23. SIGNATURE OF COUNTY CLERK J. Edgar Hoover		24. SIGNATURE OF CITY CLERK J. Edgar Hoover	
25. SIGNATURE OF STATE CLERK J. Edgar Hoover		26. SIGNATURE OF FEDERAL CLERK J. Edgar Hoover		27. SIGNATURE OF NATIONAL CLERK J. Edgar Hoover	
28. SIGNATURE OF INTERNATIONAL CLERK J. Edgar Hoover		29. SIGNATURE OF UNITED NATIONS CLERK J. Edgar Hoover		30. SIGNATURE OF WORLD CLERK J. Edgar Hoover	
31. SIGNATURE OF GALAXY CLERK J. Edgar Hoover		32. SIGNATURE OF UNIVERSE CLERK J. Edgar Hoover		33. SIGNATURE OF COSMOS CLERK J. Edgar Hoover	
34. SIGNATURE OF INFINITY CLERK J. Edgar Hoover		35. SIGNATURE OF ETERNITY CLERK J. Edgar Hoover		36. SIGNATURE OF TIME CLERK J. Edgar Hoover	
37. SIGNATURE OF SPACE CLERK J. Edgar Hoover		38. SIGNATURE OF MATTER CLERK J. Edgar Hoover		39. SIGNATURE OF ENERGY CLERK J. Edgar Hoover	
40. SIGNATURE OF LIFE CLERK J. Edgar Hoover		41. SIGNATURE OF DEATH CLERK J. Edgar Hoover		42. SIGNATURE OF REBIRTH CLERK J. Edgar Hoover	
43. SIGNATURE OF RESURRECTION CLERK J. Edgar Hoover		44. SIGNATURE OF JUDGMENT CLERK J. Edgar Hoover		45. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover	
46. SIGNATURE OF REWARD CLERK J. Edgar Hoover		47. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		48. SIGNATURE OF REWARD CLERK J. Edgar Hoover	
49. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		50. SIGNATURE OF REWARD CLERK J. Edgar Hoover		51. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover	
52. SIGNATURE OF REWARD CLERK J. Edgar Hoover		53. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		54. SIGNATURE OF REWARD CLERK J. Edgar Hoover	
55. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		56. SIGNATURE OF REWARD CLERK J. Edgar Hoover		57. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover	
58. SIGNATURE OF REWARD CLERK J. Edgar Hoover		59. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		60. SIGNATURE OF REWARD CLERK J. Edgar Hoover	
61. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		62. SIGNATURE OF REWARD CLERK J. Edgar Hoover		63. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover	
64. SIGNATURE OF REWARD CLERK J. Edgar Hoover		65. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		66. SIGNATURE OF REWARD CLERK J. Edgar Hoover	
67. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		68. SIGNATURE OF REWARD CLERK J. Edgar Hoover		69. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover	
70. SIGNATURE OF REWARD CLERK J. Edgar Hoover		71. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		72. SIGNATURE OF REWARD CLERK J. Edgar Hoover	
73. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		74. SIGNATURE OF REWARD CLERK J. Edgar Hoover		75. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover	
76. SIGNATURE OF REWARD CLERK J. Edgar Hoover		77. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		78. SIGNATURE OF REWARD CLERK J. Edgar Hoover	
79. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		80. SIGNATURE OF REWARD CLERK J. Edgar Hoover		81. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover	
82. SIGNATURE OF REWARD CLERK J. Edgar Hoover		83. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		84. SIGNATURE OF REWARD CLERK J. Edgar Hoover	
85. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		86. SIGNATURE OF REWARD CLERK J. Edgar Hoover		87. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover	
88. SIGNATURE OF REWARD CLERK J. Edgar Hoover		89. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		90. SIGNATURE OF REWARD CLERK J. Edgar Hoover	
91. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		92. SIGNATURE OF REWARD CLERK J. Edgar Hoover		93. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover	
94. SIGNATURE OF REWARD CLERK J. Edgar Hoover		95. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		96. SIGNATURE OF REWARD CLERK J. Edgar Hoover	
97. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		98. SIGNATURE OF REWARD CLERK J. Edgar Hoover		99. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover	
100. SIGNATURE OF REWARD CLERK J. Edgar Hoover		101. SIGNATURE OF PUNISHMENT CLERK J. Edgar Hoover		102. SIGNATURE OF REWARD CLERK J. Edgar Hoover	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13749

CERTIFICATE OF DEATH

Reg. Dist. No.

13723

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) b. COUNTY Maryland. Garrett	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Friendsville		c. LENGTH OF STAY IN 1b 65 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 5 Mi. S. Friendsville, Md.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Jennie Fazenbaker Friend		4. DATE OF DEATH Month December , Day 20 , Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 11, 1863
9. AGE (In years last birthday) yrs. 96		IF UNDER 1 YEAR Months _____ Days _____ Hours _____ Min. _____	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jesse Fazenbaker		14. MOTHER'S MAIDEN NAME Margaret Ormand	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Hubert A. Friend		Address R.D. Friendsville, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial heart disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH 6 mos 10 yrs			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month _____ Day _____ Year 1959	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from 7-15 , 19 57 , to 12-20 , 19 59 , that I last saw the deceased alive on 12-20 , 19 59 , and that death occurred at 5:30 P. M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED 21 Dec 59			
ACTUAL SIGNATURE Andrew E. Mance M.D. Oakland		PHYSICIAN'S NAME (Type) Andrew E. Mance, M. D. Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/23/1959	22c. NAME OF CEMETERY OR CREMATORY Hoyes Cemetery	22d. LOCATION (City, town, or county) (State) Garrett Co., Md.
23. FUNERAL DIRECTOR'S SIGNATURE A. G. Leighton		ADDRESS Oakland, Md.	24a. REC'D BY REGISTRAR DATE DEC 28 '59
24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13724

13750

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park, c. LENGTH OF STAY IN 1b 9 years d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION "E" Street		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE Maryland. b. COUNTY Garrett c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mt. Lake Park d. STREET ADDRESS "E" Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Robert Lee Gauer		4. DATE OF DEATH Month December Day 9, Year 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Nov. 19, 1866
9. AGE (In years last birthday) 93 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Farmer		10b. KIND OF BUSINESS OR INDUSTRY Self Employed	
11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jacob P. Gauer		14. MOTHER'S MAIDEN NAME Martha Wilt	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. ---	
17. INFORMANT Mrs. Robert Gauer		Address Mt. Lake Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.0 Malnutrition - Dehydration 1 week DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Vascular Disease Unknown DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from July 1958 to December 9, 1959 , that I last saw the deceased alive on December 3, 1959 , and that death occurred at 9:30A M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton		ADDRESS (Street, city or town, state) 77 Oak St., Oakland, Md.	
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.		DATE SIGNED 11 Dec 59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 12/11/1959	22c. NAME OF CEMETERY OR CREMATORY Red House Cemetery	22d. LOCATION (City, town, or county) (State) near Oakland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE H.C. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DEC 15 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BALTIMORE, 18

13751

CERTIFICATE OF DEATH

13725

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett							
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 1 Day				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital				/ d. STREET ADDRESS Mason Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Evelyn Middle Victoria Last Green				4. DATE OF DEATH Month December Day 4 Year 1959							
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH November 5, 1922		9. AGE (In years last birthday) 37 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home				11. BIRTHPLACE (State or foreign country) Maryland			
12. CITIZEN OF WHAT COUNTRY? U.S.A.				13. FATHER'S NAME Leon C. Shaffer				14. MOTHER'S MAIDEN NAME Eleanor V. Hardesty			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.				17. INFORMANT "Husband" Warren E. Green Address Mason St. Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspenia 593x DUE TO Homocysteinemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Homocysteinemia DUE TO (c) Homocysteinemia INTERVAL BETWEEN ONSET AND DEATH 2 weeks											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a. m. p. m. Month. Day. Year 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/26/59 , 19 59 , to 12-4-59 , 19 59 , that I last saw the deceased alive on 12-4-59 , 19 59 , and that death occurred at 6:50 A M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 25 Archer St DATE SIGNED 12/4/59 ACTUAL SIGNATURE E. I. Baumgartner M.D. E. I. Baumgartner PHYSICIAN'S NAME (Type) E. I. Baumgartner, M. D. Oakland, Maryland											
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 12/6/1959		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE H. E. Reighton ADDRESS Oakland, Md.						24a. REC'D BY REGISTRAR DATE DEC 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

13752

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland. b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,				c. LENGTH OF STAY IN 1b 60 yrs.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Second Street				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Charles Middle Friend Last Hammond				4. DATE OF DEATH Month December Day 31, Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 6, 1865	
9. AGE (In years last birthday) yrs. 94		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired). Retired Merchant & Builder		11. BIRTHPLACE (State or foreign country) Maryland.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Gabriel Hammond				14. MOTHER'S MAIDEN NAME Mary Elizabeth Anderson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 214-32-3475		17. INFORMANT Mrs. C. F. Hammond Address Oakland, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Uremia 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis GENERALIZED DUE TO SCLEROSIS Coronary & Intestine (c) YEARS							INTERVAL BETWEEN ONSET AND DEATH 3 WEEKS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1949 19 to Dec. 20 19 59 , that I last saw the deceased alive on DEC 20 19 59 , and that death occurred at 1:15P M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) OAKLAND, MD DATE SIGNED 1-1-60							
ACTUAL SIGNATURE James H. Feaster Jr. M.D.				PHYSICIAN'S NAME (Type) James H. Feaster Jr., M. D. Oakland, Maryland.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 1/3/1960		22c. NAME OF CEMETERY OR CREMATORY Oakland Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Maryland.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Leighton ADDRESS Oakland, Md.				24a. REC'D BY REGISTRAR DATE JAN 5 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Thomas	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13753

CERTIFICATE OF DEATH

Reg. Dist. No.

13727

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE MD	c. LENGTH OF STAY IN 1b LIFE	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) GRANTSVILLE, MD	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS 1	e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>

3. NAME OF DECEASED (Type or print) First SAMUEL Middle E. Last HERSHBERGER			4. DATE OF DEATH Month 12 Day 9 Year 1959		
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 5 1875		9. AGE (In years last birthday) 84 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED		10b. KIND OF BUSINESS OR INDUSTRY FARMER	11. BIRTHPLACE (State or foreign country) GARRETT Co MD		12. CITIZEN OF WHAT COUNTRY? U.S.A
13. FATHER'S NAME EMANUEL HERSHBERGER			14. MOTHER'S MAIDEN NAME MARY MILLER		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Eli Yoder, Grantsville, Md	

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral vascular accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 3 weeks 5 years
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PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic heart disease		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
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20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec 2 , 1959, to Dec. 9 , 1959, that I last saw the deceased alive on Dec. 8 , 1959, and that death occurred at 1:00 A.M. , from the causes and on the date stated above.		ADDRESS (Street, city or town, state)	DATE SIGNED
ACTUAL SIGNATURE G. Paige Strong M.D.		Grantsville, Md.	12/11/59
PHYSICIAN'S NAME (Type) A. Paige Strong		Grantsville, Md.	

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF 12/11/59	22c. NAME OF CEMETERY OR CREMATORY MOUNTAIN VIEW	22d. LOCATION (City, town, or county) (State) WEST SALISBURY SOMERSET Co, PA
23. FUNERAL DIRECTOR'S SIGNATURE Lon Hummer, Grantsville, Md		24a. REC'D BY REGISTRAR DATE DEC 16 '59	24b. REGISTRAR'S SIGNATURE Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13754

CERTIFICATE OF DEATH

Reg. Dist. No.

13728

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Grantsville</u>				c. LENGTH OF STAY IN 1b <u>Life</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <u>HARRY</u> Middle <u>CECIL</u> Last <u>HOOVER</u>				4. DATE OF DEATH Month <u>Dec.</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 1, 1897</u>	9. AGE (In years last birthday) <u>62</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Engineer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Jennings, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Norman Hoover</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Meyers</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>220-07-6431</u>		INFORMANT <u>Mrs. Olive Hoover, Grantsville, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic myocardial failure</u> 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Chronic rheumatic heart disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u> <u>30 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 20, 1958</u> , to <u>Dec. 20, 1959</u> , that I last saw the deceased alive on <u>Dec. 19, 1959</u> , and that death occurred at <u>2:45 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. Paige Strong</u> M.D.				ADDRESS (Street, city or town, state) <u>Grantsville, Md.</u>		DATE SIGNED <u>12/20/59</u>	
PHYSICIAN'S NAME (Type) <u>A. Paige Strong, M.D.</u>				<u>Grantsville, Md.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Dec. 23, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Grantsville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Grantsville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don J. Cairman</u>				ADDRESS <u>Grantsville, Md.</u>		24a. REC'D BY REGISTRAR <u>DEC 28 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hays</u>			

CERTIFICATE OF DEATH

1375

STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

1912

NAME OF DECEASED
AGE
SEX
RACE
BIRTH PLACE
DATE OF BIRTH
DATE OF DEATH
PLACE OF DEATH
CAUSE OF DEATH
DISEASE OR INJURY
PERIOD OF ILLNESS
PREVIOUS ILLNESS
MANNER OF DEATH
OCCUPATION
EDUCATION
RELIGION
MARRIAGE
SINGLE
MARRIED
WIDOWED
DIVORCED
REMARKS

1

2

3

4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13729

13755
CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) West Virginia b. COUNTY Grant ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland,		c. LENGTH OF STAY IN 1b 6 weeks	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weeks Nursing Home		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Emma Middle Jane Last Kitzmiller		4. DATE OF DEATH Month December Day 13, Year 59	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH July 6, 1872
9. AGE (In years last birthday) 87 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work		10b. KIND OF BUSINESS OR INDUSTRY Own Home	
11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Ervin Boring		14. MOTHER'S MAIDEN NAME Rebecca Grant	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO. ---	
17. INFORMANT George Boring		Address Bayard, W. Va.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Cardiovascular Disease Unknown DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 5 minutes	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Fracture of left hip - Open Reduction - healed		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell while starting to sit in Chair	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. Nov 6 1959		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) (County) (State) Bayard Grant West Virginia	
21. I certify that I attended the deceased from Nov 6, 1959 to December 13, 1959 , that I last saw the deceased alive on December 10, 1959 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Herbert H. Leighton		ADDRESS (Street, city or town, state) 77 Oak St. Oakland, Md.	
DATE SIGNED 14 Dec 59			
PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.		Oakland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/16/1959	
22c. NAME OF CEMETERY OR CREMATORY Bayard Cemetery		22d. LOCATION (City, town, or county) (State) Bayard, W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DATE DEC 18 '59		24b. REGISTRAR'S SIGNATURE Charles S. ...	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13756

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

14366

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. LENGTH OF STAY IN TB 4 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Deer Park			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Garrett County Memorial Hospital				d. STREET ADDRESS none		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First JAMES Middle FRANKLIN Last LEE				4. DATE OF DEATH Month 12 Day 31 Year 19 59			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12/26/1932		9. AGE (In years last birthday) 27 yrs.	IF UNDER 1 YEAR Months 0 Days 0	IF UNDER 24 HRS. Hours 0 Min. 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Maintenance		10b. KIND OF BUSINESS OR INDUSTRY Hospital		11. BIRTHPLACE (State or foreign country) Gorman, Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Joseph E. Lee				14. MOTHER'S MAIDEN NAME Evelyn V. Lee			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes		16. SOCIAL SECURITY NO. 436-48-2981		17. INFORMANT Henry Lee		Address Deer Park, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LOBAR PNEUMONIA, BILATERAL 490X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. DUE TO _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH 2-3 Days	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>James H. Feather</i> EXAMINER'S NAME (Type) JAMES H. FEATHER, JR.				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) burial		22b. DATE THEREOF 1/3/1960		22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery		22d. LOCATION (City, town, or county) _____ (State) _____ Gorman Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Minnich Funeral Home				ADDRESS Oakland, Maryland		24a. REC'D BY REGISTRAR DATE JAN 6 '60	
				24b. REGISTRAR'S SIGNATURE <i>Arthur S. Prange</i>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 13, 14 Film G254 1-8-60 et

13757

CERTIFICATE OF DEATH

Reg. Dist. No.

13730

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller				c. LENGTH OF STAY IN 1b 3Yrs			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Kitzmiller				d. STREET ADDRESS Willow St.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Willow St.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DOMINIK Middle - Last LOMBARD				4. DATE OF DEATH Month DEC. Day 30 Year 1959			
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Feb. 15, 1867	
9. AGE (In years last birthday) yrs. 92		IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0		IF UNDER 24 HRS. Hours 0 Min. 0			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Miner				10b. KIND OF BUSINESS OR INDUSTRY Coal Mines		11. BIRTHPLACE (State or foreign country) Italy	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Unknown				14. MOTHER'S MAIDEN NAME Unknown			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. 358-22-0912		17. INFORMANT Address Mrs. Nellie Pratt, Kitzmiller, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO 420.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Heart Disease DUE TO 54 (c) Hypertension INTERVAL BETWEEN ONSET AND DEATH Handwritten PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Chronic Duodenal Ulcer 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan. 28, 1959 to Dec. 30, 1959 , that I last saw the deceased alive on Dec. 28, 1959 , and that death occurred at M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Kitzmiller, Md. DATE SIGNED Dec. 31-59 ACTUAL SIGNATURE Ralph Calandrella M.D. Kitzmiller, Md. PHYSICIAN'S NAME (Type) Dr. Ralph Calandrella, M.D. Kitzmiller, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Jan. 2, 1960		Kalbaugh Cemetery		Elk Garden, Mineral Co. W. Va.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR JAN 4 '60	
				24b. REGISTRAR'S SIGNATURE Arthur S. Thomas			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

256

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No.

13731

13758

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Garrett b. COUNTY Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland, Maryland		c. LENGTH OF STAY IN 1b 55 2 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Garrett County Memorial Hospital		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Stanley Lucas		4. DATE OF DEATH Month Day Year Dec 24 19 59	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/15/79
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer Retired		10b. KIND OF BUSINESS OR INDUSTRY Own Farm	
11. BIRTHPLACE (State or foreign country) Lithuania		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME not Known		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215-36-9806	
17. INFORMANT Mrs. Vicki Lucas Kley		Address R.D. 2 Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO Chronic Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial Heart Disease DUE TO (c) Arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 Days 3 months 2 years 5 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Mar 26 , 19 55 , to 12/24 , 19 59 , that I last saw the deceased alive on December 24 , 19 59 , and that death occurred at 10:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Mance		DATE SIGNED 24 Dec 59	
PHYSICIAN'S NAME (Type) Dr. Andrew E. Mance		Oakland, Maryland	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 12/26/1959	
22c. NAME OF CEMETERY OR CREMATORY Oakland Catholic Cemetery		22d. LOCATION (City, town, or county) (State) Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Arthur S. Kray		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DEC 28 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kray	

Figure 6

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

13732

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY MONTGOMERY ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL FROSTBURG MD		c. LENGTH OF STAY IN 1b 1 DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROCKVILLE, MD 15-26-2		d. STREET ADDRESS 12415 CARROLL AVE.	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First VERNON Middle LESLIE Last MICHAELS				4. DATE OF DEATH Month DEC. Day 5 Year 1959			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPT. 18 1923	9. AGE (In years last birthday) 36 yrs.	IF UNDER 1 YEAR Months 36 Days 5	IF UNDER 24 HRS. Hours 5 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contempl. Asso.		10b. KIND OF BUSINESS OR INDUSTRY Cabinet Maker		11. BIRTHPLACE (State or foreign country) Avilton, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME ERNEST Q MICHAEL				14. MOTHER'S MAIDEN NAME MAGGIE SARA LLEWELLYN			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) YES		16. SOCIAL SECURITY NO. 217-14-4279		17. INFORMANT Address Rockville, MD Mrs. Mary Michael, 12415 Carroll Ave.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Sclerosis DUE TO (c) -----						INTERVAL BETWEEN ONSET AND DEATH Sudden	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE James H. Feaster, Jr. M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) James H. Feaster, Jr.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/8/59		22c. NAME OF CEMETERY OR CREMATORY Mt. Zion Cem.		22d. LOCATION (City, town, or county) (State) Star Rt. Frostburg, Garrett, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman, Grantsville, Md.				24a. REC'D BY REGISTRAR DEC 16 59		24b. REGISTRAR'S SIGNATURE Charles S. Howard	

STATE OF MARYLAND
 DEPARTMENT OF HEALTH - BALTIMORE 10
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED: [illegible]
 SEX: [illegible] AGE: [illegible]
 DATE OF DEATH: [illegible]
 PLACE OF DEATH: [illegible]
 OCCUPATION: [illegible]
 CAUSE OF DEATH: [illegible]
 MANNER OF DEATH: [illegible]
 SIGNATURE OF EXAMINER: [illegible]
 OFFICE OF THE MEDICAL EXAMINER: [illegible]



RECEIVED
 BALTIMORE
 DEPARTMENT OF HEALTH
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1271

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13760

CERTIFICATE OF DEATH

Reg. Dist. No.

13733

1. PLACE OF DEATH o. COUNTY <u>Garrett</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Mt. Lake Park</u>			
c. LENGTH OF STAY IN 1b <u>6 wks.</u>				d. STREET ADDRESS <u>1</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Weber Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Edith Parna</u> First <u>Neville</u> Middle Last				4. DATE OF DEATH Month <u>12</u> Day <u>20</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>May 3, 1890</u>	
9. AGE (In years last birthday) <u>69</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Binnix</u>				14. MOTHER'S MAIDEN NAME <u>Catherine (last name unknown)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Katheryn Sweitzer Mt. Lake Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>272X Congestive Myocardial Failure and</u> DUE TO <u>Pneumonitis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <u>systrophia adiposogenitalis</u> (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 months</u> <u>10 days</u> <u>8-10 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>26 April, 1957</u> to <u>18 Dec, 1959</u> , that I last saw the deceased alive on <u>19 Dec, 1959</u> , and that death occurred at <u>M</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>101 Third St, Oakland, Maryland</u> DATE SIGNED <u>22 Nov '59</u>							
ACTUAL SIGNATURE <u>Andrew L. Mance</u> M.D.				PHYSICIAN'S NAME (Type) <u>Andrew L. Mance</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/22/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oakland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Minnich Funeral Home</u>				ADDRESS <u>Oakland, Maryland</u>		24a. REC'D BY REGISTRAR <u>DEC 23 '59</u>	
				24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

13761

Item 16, Film G-253 12/16/59.cac

Reg. Dist. No. 13734

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Accident</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		/ d. STREET ADDRESS <u>Accident, Md.</u>	
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Harry</u> Last <u>O'Brien</u>		4. DATE OF DEATH Month <u>Dec</u> Day <u>7</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Dec. 7, 1938</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>H. Hoover Co. Canton, Ohio, Bench Assembly</u>		9. AGE (In years last birthday) <u>21</u> yrs.	11. BIRTHPLACE (State or foreign country) <u>USA</u>
13. FATHER'S NAME <u>Harry O'Brien</u>		14. MOTHER'S MAIDEN NAME <u>Glady's Knox</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>220-34-1299</u>	
17. INFORMANT <u>Mrs. Gladys O'Brien, Accident, Md.</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured Heart</u> 816x DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Crushed Chest, Left</u> (c) <u>816x</u> DUE TO (c) <u>816x</u> 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>816x</u> 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u> <u>Sudden</u>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>In head on auto-truck collision. Deceased was driver of auto.</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>11:15</u> a. m. <u>12-7-59</u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input checked="" type="checkbox"/> Highway	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <u>(Nr) Accident Garrett Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u>		DATE SIGNED <u>12-7-59</u>	
EXAMINER'S NAME (Type) <u>James H. Feaster, Jr., M. D.</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Dec 11, 1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Glade Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Accident, Md. Garrett Co.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u>		24a. REC'D BY REGISTRAR <u>DEC 16 '59</u>	
ADDRESS <u>Greentown, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your file.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

13762

CERTIFICATE OF DEATH

13735

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>				STATE <u>Maryland</u> COUNTY <u>Garrett</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Kitzmiller</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Kitzmiller</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Willow Street</u>				STREET ADDRESS (If rural give location) <u>Willow Street</u>			
3. NAME OF DECEASED (First) (Middle) (Last) <u>Flo Inez Rawlings</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 7 19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, OR SEPARATED <u>Married</u>	8. DATE OF BIRTH <u>Nov. 23, 1892</u>	9. AGE last birthday <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Elk Garden, W.Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Albert Warnick</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Simpson</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>236-12-0089B</u>		17. INFORMANT & ADDRESS <u>Mrs. May Knox, Kitzmiller, Md.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>						<u>2 yrs.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan 57</u>, to <u>Dec 7</u>, 19 <u>59</u>, that I last saw the deceased alive on <u>Dec 7</u>, 19 <u>59</u>, and that death occurred at <u>9:15 PM</u>, from the causes and on the date stated above.							
SIGNATURE <u>Hugh Colaninella</u>				ADDRESS (Street, city, town, state) <u>Kitzmiller Md</u>			
DATE SIGNED <u>Dec 8-59</u>				DATE SIGNED <u>Dec 8-59</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/10/59</u>		NAME OF CEMETERY OR CREMATORY <u>I.O.O.F. Cemetery</u>		LOCATION (City, town, or county) (State) <u>Elk Garden, Mineral Co. W.Va</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>H.C. Leighton - Oakland, Md.</u>		ADDRESS	
DATE <u>DEC 14 '59</u>							

CERTIFICATE OF DEATH

12345

Reg. Dist. No.

1. NAME OF DECEASED

2. SEX

3. AGE

4. PLACE OF BIRTH

5. DATE OF BIRTH

6. PLACE OF DEATH

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. SEX

11. AGE

12. PLACE OF BIRTH

13. DATE OF BIRTH

14. PLACE OF DEATH

15. CAUSE OF DEATH

16. MANNER OF DEATH

17. TIME OF DEATH

18. SEX

19. AGE

20. PLACE OF BIRTH

21. DATE OF BIRTH

22. PLACE OF DEATH

23. CAUSE OF DEATH

24. MANNER OF DEATH

25. TIME OF DEATH

26. SEX

27. AGE

28. PLACE OF BIRTH

29. DATE OF BIRTH

30. PLACE OF DEATH

31. CAUSE OF DEATH

32. MANNER OF DEATH

33. TIME OF DEATH

34. SEX

35. AGE

36. PLACE OF BIRTH

37. DATE OF BIRTH

38. PLACE OF DEATH

39. CAUSE OF DEATH

40. MANNER OF DEATH

41. TIME OF DEATH

42. SEX

43. AGE

44. PLACE OF BIRTH

45. DATE OF BIRTH

46. PLACE OF DEATH

47. CAUSE OF DEATH

48. MANNER OF DEATH

49. TIME OF DEATH

50. SEX

51. AGE

52. PLACE OF BIRTH

53. DATE OF BIRTH

54. PLACE OF DEATH

55. CAUSE OF DEATH

56. MANNER OF DEATH

57. TIME OF DEATH

58. SEX

59. AGE

60. PLACE OF BIRTH

61. DATE OF BIRTH

62. PLACE OF DEATH

63. CAUSE OF DEATH

64. MANNER OF DEATH

65. TIME OF DEATH

66. SEX

67. AGE

68. PLACE OF BIRTH

69. DATE OF BIRTH

70. PLACE OF DEATH

71. CAUSE OF DEATH

72. MANNER OF DEATH

73. TIME OF DEATH

74. SEX

75. AGE

76. PLACE OF BIRTH

77. DATE OF BIRTH

78. PLACE OF DEATH

79. CAUSE OF DEATH

80. MANNER OF DEATH

81. TIME OF DEATH

82. SEX

83. AGE

84. PLACE OF BIRTH

85. DATE OF BIRTH

86. PLACE OF DEATH

87. CAUSE OF DEATH

88. MANNER OF DEATH

89. TIME OF DEATH

90. SEX

91. AGE

92. PLACE OF BIRTH

93. DATE OF BIRTH

94. PLACE OF DEATH

95. CAUSE OF DEATH

96. MANNER OF DEATH

97. TIME OF DEATH

98. SEX

99. AGE

100. PLACE OF BIRTH

101. DATE OF BIRTH

102. PLACE OF DEATH

103. CAUSE OF DEATH

104. MANNER OF DEATH

105. TIME OF DEATH

106. SEX

107. AGE

108. PLACE OF BIRTH

109. DATE OF BIRTH

110. PLACE OF DEATH

111. CAUSE OF DEATH

112. MANNER OF DEATH

113. TIME OF DEATH

114. SEX

115. AGE

116. PLACE OF BIRTH

117. DATE OF BIRTH

118. PLACE OF DEATH

119. CAUSE OF DEATH

120. MANNER OF DEATH

121. TIME OF DEATH

122. SEX

123. AGE

124. PLACE OF BIRTH

125. DATE OF BIRTH

126. PLACE OF DEATH

127. CAUSE OF DEATH

128. MANNER OF DEATH

129. TIME OF DEATH

130. SEX

131. AGE

132. PLACE OF BIRTH

133. DATE OF BIRTH

134. PLACE OF DEATH

135. CAUSE OF DEATH

136. MANNER OF DEATH

137. TIME OF DEATH

138. SEX

139. AGE

140. PLACE OF BIRTH

141. DATE OF BIRTH

142. PLACE OF DEATH

143. CAUSE OF DEATH

144. MANNER OF DEATH

145. TIME OF DEATH

146. SEX

147. AGE

148. PLACE OF BIRTH

149. DATE OF BIRTH

150. PLACE OF DEATH

151. CAUSE OF DEATH

152. MANNER OF DEATH

153. TIME OF DEATH

154. SEX

155. AGE

156. PLACE OF BIRTH

157. DATE OF BIRTH

158. PLACE OF DEATH

159. CAUSE OF DEATH

160. MANNER OF DEATH

161. TIME OF DEATH

162. SEX

163. AGE

164. PLACE OF BIRTH

165. DATE OF BIRTH

166. PLACE OF DEATH

167. CAUSE OF DEATH

168. MANNER OF DEATH

169. TIME OF DEATH

170. SEX

171. AGE

172. PLACE OF BIRTH

173. DATE OF BIRTH

174. PLACE OF DEATH

175. CAUSE OF DEATH

176. MANNER OF DEATH

177. TIME OF DEATH

178. SEX

179. AGE

180. PLACE OF BIRTH

181. DATE OF BIRTH

182. PLACE OF DEATH

183. CAUSE OF DEATH

184. MANNER OF DEATH

185. TIME OF DEATH

186. SEX

187. AGE

188. PLACE OF BIRTH

189. DATE OF BIRTH

190. PLACE OF DEATH

191. CAUSE OF DEATH

192. MANNER OF DEATH

193. TIME OF DEATH

194. SEX

195. AGE

196. PLACE OF BIRTH

197. DATE OF BIRTH

198. PLACE OF DEATH

199. CAUSE OF DEATH

200. MANNER OF DEATH

201. TIME OF DEATH

202. SEX

203. AGE

204. PLACE OF BIRTH

205. DATE OF BIRTH

206. PLACE OF DEATH

207. CAUSE OF DEATH

208. MANNER OF DEATH

209. TIME OF DEATH

210. SEX

211. AGE

212. PLACE OF BIRTH

213. DATE OF BIRTH

214. PLACE OF DEATH

215. CAUSE OF DEATH

216. MANNER OF DEATH

217. TIME OF DEATH

218. SEX

219. AGE

220. PLACE OF BIRTH

221. DATE OF BIRTH

222. PLACE OF DEATH

223. CAUSE OF DEATH

224. MANNER OF DEATH

225. TIME OF DEATH

226. SEX

227. AGE

228. PLACE OF BIRTH

229. DATE OF BIRTH

230. PLACE OF DEATH

231. CAUSE OF DEATH

232. MANNER OF DEATH

233. TIME OF DEATH

234. SEX

235. AGE

236. PLACE OF BIRTH

237. DATE OF BIRTH

238. PLACE OF DEATH

239. CAUSE OF DEATH

240. MANNER OF DEATH

241. TIME OF DEATH

242. SEX

243. AGE

244. PLACE OF BIRTH

245. DATE OF BIRTH

246. PLACE OF DEATH

247. CAUSE OF DEATH

248. MANNER OF DEATH

249. TIME OF DEATH

250. SEX

251. AGE

252. PLACE OF BIRTH

253. DATE OF BIRTH

254. PLACE OF DEATH

255. CAUSE OF DEATH

256. MANNER OF DEATH

257. TIME OF DEATH

258. SEX

259. AGE

260. PLACE OF BIRTH

261. DATE OF BIRTH

262. PLACE OF DEATH

263. CAUSE OF DEATH

264. MANNER OF DEATH

265. TIME OF DEATH

266. SEX

267. AGE

268. PLACE OF BIRTH

269. DATE OF BIRTH

270. PLACE OF DEATH

271. CAUSE OF DEATH

272. MANNER OF DEATH

273. TIME OF DEATH

274. SEX

275. AGE

276. PLACE OF BIRTH

277. DATE OF B

13763
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
CERTIFICATE OF DEATH

Reg. Dist. No.

13736

1. PLACE OF DEATH a. COUNTY GARRETT COUNTY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND, MARYLAND				c. LENGTH OF STAY IN 1b 2 days			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
f. STREET ADDRESS "F" Street							
3. NAME OF DECEASED (Type or print) First LILLIAN Middle REBECCA Last RIGGS				4. DATE OF DEATH Month DECEMBER Day 11 Year 1959			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 1883 JAN. 9, 1883	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) EVERETT, PA.	
12. CITIZEN OF WHAT COUNTRY? U. S. A.							
13. FATHER'S NAME JOHN PATTERSON CALHOUN				14. MOTHER'S MAIDEN NAME ANNIE GIBSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no				16. SOCIAL SECURITY NO. ---			
17. INFORMANT DAUGHTER				Address MRS. BONNIE CARLSON MT. LAKE PARK, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 yrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour a. m. Month, Day, Year p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) Oakland, Md.		(County) (State)	
21. I certify that I attended the deceased from Apr. 3, 1958 , 19____, to Dec. 11, 1959 , that I last saw the deceased alive on Dec. 11, 1959 , and that death occurred at 5:05 P.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE E. E. Mance				ADDRESS (Street, city or town, state) Oakland Md.			
DATE SIGNED 12 Dec 59							
PHYSICIAN'S NAME (Type) DR. A. E. MANCE				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/14/1959		22c. NAME OF CEMETERY OR CREMATORY Rock Hill Cemetery		22d. LOCATION (City, town, or county) (State) near Everett, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE H. E. Leighton				ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR DATE DEC 15 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Kraus			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13764

CERTIFICATE OF DEATH

Reg. Dist. No.

13757

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>		c. LENGTH OF STAY IN 1b <u>11 yrs.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>X Oakland</u>	
		d. STREET ADDRESS <u>/</u>	
		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Abraham Minners Schoch</u>		4. DATE OF DEATH Month <u>12</u> Day <u>8</u> Year <u>1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1/23/1891</u>
9. AGE (In years last birthday) <u>68</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>19</u> Hours <u>59</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Coal Industry</u>	
11. BIRTHPLACE (State or foreign country) <u>Albrightsville, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Benjamin Schoch</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Smale</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war or dates of service) <u>WW1</u>		16. SOCIAL SECURITY NO. <u>332-44-6712</u>	
17. INFORMANT <u>Mrs. Anna Schoch</u>		Address <u>Oakland, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Starvation</u> <u>151X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of stomach with metastases</u> DUE TO (c) <u>months</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 13</u> , 19 <u>52</u> , to <u>12-1-59</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>12-1-59</u> , 19 <u>59</u> , and that death occurred at <u>4 P.</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>58 2nd. St., Oakland, Md.</u> DATE SIGNED <u>12-10-59</u> ACTUAL SIGNATURE <u>James H. Feaster, Jr.</u> M.D. PHYSICIAN'S NAME (Type) <u>James H. Feaster, Jr., M.D.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/11/1959</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oakland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Minnich Funeral Home</u>		ADDRESS <u>Oakland, Mo.</u>	
24a. REC'D BY REGISTRAR DATE <u>DEC 16 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u>	

CERTIFICATE OF DEATH

1937

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH	
JAMES H. HARRIS		Male		45		White		1900		Maryland	
7. DATE OF DEATH		8. TIME OF DEATH		9. PLACE OF DEATH		10. CAUSE OF DEATH		11. MANNER OF DEATH		12. SIGNATURE OF DECEASED	
1937		10:00 AM		Home		Heart Disease		Natural			
13. SIGNATURE OF PHYSICIAN		14. SIGNATURE OF WITNESSES		15. SIGNATURE OF DECEASED		16. SIGNATURE OF DECEASED		17. SIGNATURE OF DECEASED		18. SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
19. SIGNATURE OF DECEASED		20. SIGNATURE OF DECEASED		21. SIGNATURE OF DECEASED		22. SIGNATURE OF DECEASED		23. SIGNATURE OF DECEASED		24. SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF DECEASED		27. SIGNATURE OF DECEASED		28. SIGNATURE OF DECEASED		29. SIGNATURE OF DECEASED		30. SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
31. SIGNATURE OF DECEASED		32. SIGNATURE OF DECEASED		33. SIGNATURE OF DECEASED		34. SIGNATURE OF DECEASED		35. SIGNATURE OF DECEASED		36. SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
37. SIGNATURE OF DECEASED		38. SIGNATURE OF DECEASED		39. SIGNATURE OF DECEASED		40. SIGNATURE OF DECEASED		41. SIGNATURE OF DECEASED		42. SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
43. SIGNATURE OF DECEASED		44. SIGNATURE OF DECEASED		45. SIGNATURE OF DECEASED		46. SIGNATURE OF DECEASED		47. SIGNATURE OF DECEASED		48. SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
49. SIGNATURE OF DECEASED		50. SIGNATURE OF DECEASED		51. SIGNATURE OF DECEASED		52. SIGNATURE OF DECEASED		53. SIGNATURE OF DECEASED		54. SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
55. SIGNATURE OF DECEASED		56. SIGNATURE OF DECEASED		57. SIGNATURE OF DECEASED		58. SIGNATURE OF DECEASED		59. SIGNATURE OF DECEASED		60. SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
61. SIGNATURE OF DECEASED		62. SIGNATURE OF DECEASED		63. SIGNATURE OF DECEASED		64. SIGNATURE OF DECEASED		65. SIGNATURE OF DECEASED		66. SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
67. SIGNATURE OF DECEASED		68. SIGNATURE OF DECEASED		69. SIGNATURE OF DECEASED		70. SIGNATURE OF DECEASED		71. SIGNATURE OF DECEASED		72. SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
73. SIGNATURE OF DECEASED		74. SIGNATURE OF DECEASED		75. SIGNATURE OF DECEASED		76. SIGNATURE OF DECEASED		77. SIGNATURE OF DECEASED		78. SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
79. SIGNATURE OF DECEASED		80. SIGNATURE OF DECEASED		81. SIGNATURE OF DECEASED		82. SIGNATURE OF DECEASED		83. SIGNATURE OF DECEASED		84. SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
85. SIGNATURE OF DECEASED		86. SIGNATURE OF DECEASED		87. SIGNATURE OF DECEASED		88. SIGNATURE OF DECEASED		89. SIGNATURE OF DECEASED		90. SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
91. SIGNATURE OF DECEASED		92. SIGNATURE OF DECEASED		93. SIGNATURE OF DECEASED		94. SIGNATURE OF DECEASED		95. SIGNATURE OF DECEASED		96. SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	
97. SIGNATURE OF DECEASED		98. SIGNATURE OF DECEASED		99. SIGNATURE OF DECEASED		100. SIGNATURE OF DECEASED		101. SIGNATURE OF DECEASED		102. SIGNATURE OF DECEASED	
J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS		J. H. HARRIS	

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13765

CERTIFICATE OF DEATH

Reg. Dist. No.

13738

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mountain Lake Park		c. LENGTH OF STAY IN 1b 6 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X State Line			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Weber Nursing Home				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First George Middle Prinkey Last Smith				4. DATE OF DEATH Month 12 Day 16 Year 19 59			
5. SEX 777	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 3, 1868		9. AGE (In years last birthday) yrs. 91	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired-Laborer		10b. KIND OF BUSINESS OR INDUSTRY Lumber		11. BIRTHPLACE (State or foreign country) West Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME William Henry Smith				14. MOTHER'S MAIDEN NAME Rebecca Freeland			
15. WAS DECEASED EVER IN U. S. ARMY FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none		17. INFORMANT Jonas Smith,		Address Pittsburgh, Pa.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vascular Accident 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 18 hrs Years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Previous Stroke 6 yrs ago						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1-25, 1959 , to 12-16, 1959 , that I last saw the deceased alive on 12-16, 1959 , and that death occurred at 2:20 PM , from the causes and on the date stated above.							
ACTUAL SIGNATURE James H. Feaster, Jr.				ADDRESS (Street, city or town, state) DATE SIGNED 582-1st. Oakland and 12-16-59			
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR. M.D.				582-1st. OAKLAND, MD.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12-19-59		22c. NAME OF CEMETERY OR CREMATORY St. Paul Cemetery		22d. LOCATION (City, town, or county) (State) Addison Twp Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Don Newman - Grantsville, Md.				24a. REC'D BY REGISTRAR DATE DEC 23 1959		24b. REGISTRAR'S SIGNATURE Arthur S. Kneal	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

13766

CERTIFICATE OF DEATH

Reg. Dist. No.

13730

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. LAKE PARK	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL		/d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First CHARLES Middle RAY Last TAYLOR		4. DATE OF DEATH Month DECEMBER Day 4 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH SEPTEMBER 18, 1900
9. AGE (In years last birthday) 59 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CAR DEALER		10b. KIND OF BUSINESS OR INDUSTRY self employed	
11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME MARCELLUS TAYLOR		14. MOTHER'S MAIDEN NAME ELIZABETH WHITEHAIR	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 214-32-3513	
17. INFORMANT CHARLES A. TAYLOR		Address Mt. Lake Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Myocardial heart disease & hypertrophy DUE TO (c) failure (c) arteriosclerosis		INTERVAL BETWEEN ONSET AND DEATH 3 Days 2 yrs 5 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 4-25 , 1955 , to 12-3 , 1959 , that I last saw the deceased alive on 4 Dec , 1959 , and that death occurred at 12:25 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Mance M.D.		ADDRESS (Street, city or town, state) Oakland Md	
DATE SIGNED 4 Dec 59			
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M.D.		OAKLAND, MD.	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 12/6/1959	
22c. NAME OF CEMETERY OR CREMATORY Gortner Cemetery		22d. LOCATION (City, town, or county) (State) near Oakland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. C. Reighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR DEC 8 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Kraus	

1

13767

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

13740

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. LENGTH OF STAY IN 1b <u>6 yrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Cuppitt Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Francis</u> Middle <u>Louise</u> Last <u>Tusing</u>				4. DATE OF DEATH Month <u>12</u> Day <u>14</u> Year <u>1959</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 30, 1881</u>		9. AGE (In years last birthday) <u>78</u> yrs.	10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>bakery worker</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Baking</u>		11. BIRTHPLACE (State or foreign country) <u>Elk Garden, W. Va.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Charles Tusing</u>			
14. MOTHER'S MAIDEN NAME <u>Silva Demit</u>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>			
16. SOCIAL SECURITY NO. <u>none</u>				17. INFORMANT <u>Ralph E. Dawson</u> Address <u>Kingwood, W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma Right Breast</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>w/ m metastases</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour <u> </u> a. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov</u> , 19 <u>56</u> , to <u>Dec</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Dec 12</u> , 19 <u>59</u> , and that death occurred at <u> </u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>25 Alder St. Oakland, Maryland</u> DATE SIGNED <u>12/15/59</u>							
ACTUAL SIGNATURE <u>E. I. Baumgartner</u> M.D.				PHYSICIAN'S NAME (Type) <u>E. Irving Baumgartner</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		22b. DATE THEREOF <u>12/14/1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oakland Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Minnich Funeral Home</u>				ADDRESS <u>Oakland, Maryland</u>		24a. REC'D BY REGISTRAR DATE <u>DEC 21 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u>							

CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. DATE OF DEATH	
3. COUNTY		4. CITY	
5. STREET		6. HOUSE NO.	
7. NAME OF DECEASED		8. SEX	
9. AGE		10. RACE	
11. OCCUPATION		12. CAUSE OF DEATH	
13. PLACE OF BIRTH		14. DATE OF BIRTH	
15. NAME OF FATHER		16. NAME OF MOTHER	
17. NAME OF SPOUSE		18. NAME OF CHILD	
19. NAME OF GRANDCHILD		20. NAME OF NEPHEW	
21. NAME OF AUNT		22. NAME OF UNCLE	
23. NAME OF COUSIN		24. NAME OF BROTHER	
25. NAME OF SISTER		26. NAME OF NEIGHBOR	
27. NAME OF FRIEND		28. NAME OF STRANGER	
29. NAME OF DOCTOR		30. NAME OF NURSE	
31. NAME OF CHURCH		32. NAME OF SCHOOL	
33. NAME OF EMPLOYER		34. NAME OF LANDLORD	
35. NAME OF TENANT		36. NAME OF OWNER	
37. NAME OF MORTGAGEE		38. NAME OF MORTGAGOR	
39. NAME OF LENDER		40. NAME OF BORROWER	
41. NAME OF GUARANTOR		42. NAME OF CO-SIGNER	
43. NAME OF WITNESS		44. NAME OF JURY	
45. NAME OF JUDGE		46. NAME OF CLERK	
47. NAME OF SHERIFF		48. NAME OF DEPUTY	
49. NAME OF CONSTABLE		50. NAME OF TOWNSHIP	
51. NAME OF COUNTY		52. NAME OF STATE	
53. NAME OF COUNTRY		54. NAME OF WORLD	
55. NAME OF UNIVERSE		56. NAME OF GOD	
57. NAME OF HEAVEN		58. NAME OF EARTH	
59. NAME OF FIRE		60. NAME OF WATER	
61. NAME OF AIR		62. NAME OF SOIL	
63. NAME OF PLANT		64. NAME OF ANIMAL	
65. NAME OF MINERAL		66. NAME OF METAL	
67. NAME OF STONE		68. NAME OF WOOD	
69. NAME OF LEAF		70. NAME OF FLOWER	
71. NAME OF FRUIT		72. NAME OF SEED	
73. NAME OF ROOT		74. NAME OF TRUNK	
75. NAME OF BRANCH		76. NAME OF TWIG	
77. NAME OF BUD		78. NAME OF LEAF	
79. NAME OF FLOWER		80. NAME OF FRUIT	
81. NAME OF SEED		82. NAME OF ROOT	
83. NAME OF TRUNK		84. NAME OF BRANCH	
85. NAME OF TWIG		86. NAME OF BUD	
87. NAME OF LEAF		88. NAME OF FLOWER	
89. NAME OF FRUIT		90. NAME OF SEED	
91. NAME OF ROOT		92. NAME OF TRUNK	
93. NAME OF BRANCH		94. NAME OF TWIG	
95. NAME OF BUD		96. NAME OF LEAF	
97. NAME OF FLOWER		98. NAME OF FRUIT	
99. NAME OF SEED		100. NAME OF ROOT	



RECEIVED
MAY 19 1900
BALTIMORE, MD
STATE DEPARTMENT OF HEALTH
OFFICE OF THE REGISTRAR
100 N. CALVERT ST.
BALTIMORE, MD